STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G496	A. BUILDING 00 B. WING	07/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	2333 WESTDALE CT KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the investigation of complaint #IN00151089. Complaint #IN00151089: SUBSTANTIATED, Federal and State deficiencies related to the allegations are cited at W149 and W153. Dates of Survey: 7/7, 7/8, 7/9, 7/10, and 7/11/2014. Facility Number: 001010 Provider Number: 15G496 AIM Number: 100245040 Surveyor: Susan Eakright, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/21/14 by Ruth Shackelford, QIDP.	W000000	In response to the findings of the Complaint Surveyconducted on July 11, 2014, and to ensure compliance with all establishedstandards and policies and procedures, the agency will implement the followingplan of corrections: All Residential House Managers will be instructed toconduct a training on incident reporting for all staff working in the home on aquarterly basis during formal staff meetings. The Residential House Managerswill then be required to submit meeting agendas and record of trainings to theDirector of Residential Services to ensure that the required training wascompleted. In the event that an incident is not reported to theappropriate supervisory staff in a timely manner, the staff that were involvedin or had knowledge of the incident that occurred will be retrained andcounseled on incident reporting and agency policies and procedures	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			in regardsto incident reporting. To ensure that all clients residing in the groupsetting do not receive further repercussions or ramifications following BDDSreportable incidents that occur in the home the agency will assume that allresidences in the home have been affected by the incident that occurred.Therefore, in the event that any such incidents should occur again, theResidential Services Department will contact the agency Behavioral Consultantto address the events. The Behavior Consultant will meet with each client todiscuss said events. When all meetings have been completed, the BehaviorConsultant will submit a report that will include who was present for meetingsand what was discussed. Notations of these meetings will be place in all clientfiles. If it is determined that further attention is needed, the Behavior Consultantwill conduct follow-up meetings	

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			with affected clients and QualifiedDevelopmental Disabilities Professional (QDDP). *Refer to Appendix A behavior consultation form to be used.*	
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 1 of 7 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (client A), the facility neglected to immediately report an allegation of client A being left unsupervised and neglected to ensure staff were on duty to supervise client A based on client A's identified needs. Findings include: On 7/7/14 at 2:16pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 04/1/14 through 07/07/14 and indicated the following: -A 6/15/14 BDDS report for an incident on 6/14/14 at 5:45pm, indicated "it was reported to the QDDP (Qualified Developmental Disabilities Professional) around 8:00am this morning 6/15/14 that	W000149	**To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following correction actions will be implemented:** 1) All staff located at the location of 2333 Westdale Court (Westdale group home) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13:Incident Reporting. Completed Record of Trainings will be obtained and submitted upon completion of training. *Refer to Appendix B for Record of Training form to be used.*	08/10/2014

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	the consumers of the Westdale Group Home reported to staff [name] (when that staff reported for duty) that [client A] had been left in the house unattended when all else (sic) left on an outing yesterday (6/14/14)." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) "spoke with a few consumers who verified this claim" and an investigation was initiated. The report indicated on 6/15/14 the two staff on duty were suspended at that time. On 7/7/14 at 2:16pm, the facility's 6/16/14 investigation indicated client A was "left home alone" on 6/14/14 and the facility's staff failed to immediately report the allegation. The investigation indicated "Substantiated the findings to support the event as described," client A was left at home alone for "about 5 minutes" because he was "asleep" in his bedroom. The investigation results indicated the clients were leaving to go out to eat in the community, the clients loaded on the van with two staff, and once at the restaurant it was discovered that client A was not on the van. The investigation included witness statements from the staff in which the staff indicated they did not immediately report the allegation, however the clients from the group home reported to a different staff.			

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	-A 6/15/14 witness statement from discharged staff (DS #1) indicated client A was left home "alone." DS #1 stated "[client A] was asleep in his bedroom...Did you notify anybody that this happened? (Response) No, didn't know who to tell...You didn't think to call the on call? (Response) with everything going on, I didn't even think about it." -A 6/15/14 witness statement from DS #2 indicated client A was left home alone without supervision. DS #2 stated "[client A] didn't even know, he was still sleeping. Did you report this to anyone? (Response) No, I didn't." -A 6/15/14 witness statement from the QIDP indicated "Sunday morning 6/15/14 staff at Westdale group home text(ed) me to inform me that some consumers were reporting to him that on Saturday afternoon 6/14/14 staff had left [client A] alone at the house...." Client A's record was reviewed on 7/8/14 at 11:10am. Client A's 1/10/14 ISP (Individual Support Plan) and 3/2012 BSP (Behavior Support Plan) indicated client A should be supervised by the facility staff. Client A's ISP and BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Property Destruction/abuse, Resists supervision,			

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	and Extreme Irritability. Client A's ISP and BSP indicated client A lived in a group home with twenty-four hour staff supervision. Client A's BSP indicated "...Staff will monitor [Client A] every 15 minutes during private time to ensure [client A] is not engaging in potentially harmful activities. Staff will document the 15 minute checks during private time for monitoring and safety purposes." Client A's ISP indicated goals/objectives to dial his parents phone number, to wear his hearing aid on a daily basis, to wear his glasses, to check his blood sugar, to review how much money an item costs, to display appropriate social interactions, to refrain from gossiping, to comply with staff requests, to clean his room, to prepare a side dish, to put away his clothing, to shave his face, to use mouthwash, and to follow a diabetic diet. On 7/7/14 at 3:30pm, an interview with the QIDP, VPRS (Vice President of Residential Services), and the agency nurse was conducted. The three administrative staff stated client A was "not safe" home alone. The VPRS and the QIDP both indicated client A lacked the skills to react in an emergency, phone skills, exiting the group home, and independence. The VPRS and QIDP both stated "it was neglect" when client A was left home alone and "it was neglect			

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	when the (two) staff tried to cover it up." The VPRS indicated the two staff continued and finished their shift that night on 6/14/14 and were suspended on 6/15/14 after the clients from the group home reported the incident. The VPRS stated "no staff" had reported the allegation before the clients reported it to a different staff on 6/15/14 who contacted the QIDP. The VPRS indicated the facility staff neglected to provide supervision for client A and neglected to immediately report the incident to the administrator per BDDS policy and procedure. On 7/7/14 at 3:30pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." On 7/7/14 at 3pm, a record review was conducted of the facility's undated policy and procedures for Abuse, Neglect, Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need			

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	requirements such as food, shelter, clothing and to provide a safe environment...." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law. This federal tag relates to complaint #IN00151089. 9-3-2(a)			
W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 1 of 7 BDDS (Bureau of Developmental Disabilities Services) Reports reviewed (client A), the facility failed to immediately report an allegation of neglect (client A being left home unsupervised) in accordance with State Law. Findings include:	W000153	**To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following correction actions will be implemented:** 1) Alls taff located at the location of 2333 Westdale Court (Westdale group home) will be re-trained on the agency Personnel Policies and Procedures, Policy III:13:Incident	08/10/2014

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	On 7/7/14 at 2:16pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 04/1/14 through 07/07/14 and indicated the following: -A 6/15/14 BDDS report for an incident on 6/14/14 at 5:45pm, indicated "it was reported to the QDDP (Qualified Developmental Disabilities Professional) around 8:00am this morning 6/15/14 that the consumers of the Westdale Group Home reported to staff [name] (when that staff reported for duty) that [client A] had been left in the house unattended when all else (sic) left on an outing yesterday (6/14/14)." The report indicated the QIDP (Qualified Intellectual Disabilities Professional) "spoke with a few consumers who verified this claim" and an investigation was initiated. The report indicated on 6/15/14 the two staff on duty were suspended at that time. On 7/7/14 at 2:16pm, the facility's 6/16/14 investigation indicated client A was "left home alone" on 6/14/14 and the facility's staff failed to immediately report the allegation. The investigation indicated "Substantiated the findings to support the event as described," client A was left at home alone for "about 5 minutes" because he was "asleep" in his		Reporting. Completed Record of Trainings will be obtained and submitted upon completion of training. *Refer to Appendix B for Record of Training form to be used.*	

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	bedroom. The investigation results indicated the clients were leaving to go out to eat in the community, the clients loaded on the van with two staff, and once at the restaurant it was discovered that client A was not on the van. The investigation included witness statements from the staff in which the staff indicated they did not immediately report the allegation, however the clients from the group home reported to a different staff. -A 6/15/14 witness statement from discharged staff (DS #1) indicated client A was left home "alone." DS #1 stated "[client A] was asleep in his bedroom...Did you notify anybody that this happened? (Response) No, didn't know who to tell...You didn't think to call the on call? (Response) with everything going on, I didn't even think about it." -A 6/15/14 witness statement from DS #2 indicated client A was left home alone without supervision. DS #2 stated "[client A] didn't even know, he was still sleeping. Did you report this to anyone? (Response) No, I didn't." -A 6/15/14 witness statement from the QIDP indicated "Sunday morning 6/15/14 staff at Westdale group home text (ed) me to inform me that some consumers were reporting to him that on			

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	Saturday afternoon 6/14/14 staff had left [client A] alone at the house...." On 7/7/14 at 3:30pm, an interview with the QIDP, VPRS (Vice President of Residential Services), and the agency nurse was conducted. The three administrative staff stated client A was "not safe" home alone. The VPRS and the QIDP both indicated client A lacked the skills to react in an emergency, phone skills, exiting the group home, and independence. The VPRS and QIDP both indicated the incident was not immediately reported to the facility's administrator and should have been. This federal tag relates to complaint #IN00151089. 9-3-2(a)			